With a vote of 51-49, the Senate passed a tax overhaul bill recently that included a repeal of the Affordable Care Act’s (ACA) individual mandate, which requires people to buy a health insurance policy or pay a penalty. The vote was mostly along party lines.

Sen. Amy Klobuchar (D-Minn.) said that repealing the mandate “would kick 13 million people off of their health insurance by 2027, and increase individual market premiums by 10%,” (based on numbers that were released by the Congressional Budget Office in its analysis of the repeal’s efforts). “We should be helping with premiums, not increasing them. These increases] mean less money in the pockets of middle class Americans, less money for retirement, and less money for college.” Instead of passing this provision in the tax bill, “the American people want us to work together to fix the ACA,” Klobuchar said.

Sen. Susan Collins (R-Maine) said she expected that before there was a final vote in both chambers on the tax bill, Congress would first pass the Alexander-Murray bill, along with a bill by Collins and Sen. Bill Nelson (D-Fla.) that would provide health insurers with reinsurance for high-cost patients. But a group of conservative House Republicans said they would oppose such a plan, according to media reports.

Senator Ron Wyden (D-Ore.) said the provision to repeal the individual mandate “would also be a dagger in the heart of the ACA, causing millions to lose their coverage and raising costs for millions more by gutting the personal responsibility portion of the ACA.” Sen. Pat Toomey (R-Pa.) said that Wyden’s comment “is a damning indictment that it only works if people are forced to buy the product ... It’s so badly designed that people won’t buy it voluntarily, despite huge subsidies.”

The next step includes hammering out a version that satisfies both members of the Senate and the House, which passed its own tax bill November 16th.

MIPS 2018: The Good, The Bad, And The Ugly
Coding and Compliance Tips by Lori Shore, CPC, RCC

The Good
More small providers will not have to participate in the MIPS program. The low volume threshold to be considered an eligible clinician has been raised from 100 to 200 Medicare patients and from $30,000 to $90,000 in Medicare payments. Small practices, defined as those with less than 15 providers, will be given five bonus points, as well as three points instead of one for measures not meeting the 30 claim low volume threshold. Providers that treat “complex” patients, based on the number of patients treated in Hierarchical Condition categories, may also be eligible for five bonus points.

The Bad
The threshold for successfully completing the MIPS program will be raised from three points to 15 points and a full year of data must be reported. The data completeness threshold has been raised from 50% of all patients to 60%. The cost will be counted as 10% of the MIPS composite score for 2018 with the percentage coming from the Quality category. “Topped out” measures will be removed and scored on a four-year phase-out. Topped out measures for 2018 include: 21 – Prophylactic Antibiotics, 23 – Venous Thromboembolism Prophylaxis, Measure 52 – Chronic COPD, Measure 224 – Overutilization of Imaging in Melanoma, Measure 262 – Image confirmation of successful excision of Image-localized breast lesions and Measure 359 – Standardized nomenclature for CT.

The Ugly
CMS has basically given a pass to those affected by the many natural disasters by re-weighting their MIPS requirements to 0% for 2018. This includes all clinicians impacted by hurricanes Irma, Harvey, and Maria, as well as other natural disasters.

Prepare now by choosing your reporting method for 2018.
What Medicare’s 2018 Final Rules Mean For Radiology

9:05 AM on November 9, 2017 by The Imaging Performance Partnership. The Advisory Board Company (ABC). is the owner and publisher of this article.

Last week, the Centers for Medicare and Medicaid Services (CMS) released final rules governing hospital outpatient facility and provider payments for calendar year (CY) 2018. Included in the rules are payment and regulatory updates that are important for imaging programs to understand as they consider their strategy and financial outlook for 2018 and beyond.

To help you prepare for changes and ensure future success, we read through the more than 2,500 pages and identified four key takeaways below for imaging leaders and radiologists. For more on how the 2018 Medicare Final Rules affect your imaging strategy, join us for a web conference on December 7.

1. Hospital payments rise, clinician payments flat, and Independent Diagnostic Testing Facilities payments fall

Hospital outpatient payments: CMS finalized a 1.35% increase in payment for hospital outpatient services, which is slightly less than the proposed 1.75%. However, hospitals can expect to see an additional 3.2% bump in outpatient payment rates for all non-drug services, including imaging procedures, due to a $1.6 billion cut in 340B payments.

Clinician payments: CMS finalized the proposed 2018 conversion factor at $35.99, only about 10 cents greater than the 2017 conversion factor.

CMS estimates that, in aggregate, reimbursement updates for physicians will hover between 0% and 1% for radiology specialties. The notable exception is for diagnostic testing facilities, which CMS estimates will see a 4% reimbursement reduction due to a drop in practice expense RVUs.

Impact on radiology: While there are few overall payment cuts for imaging in 2018, the 4% reduction to reimbursement for diagnostic testing facilities demonstrates that CMS continues to view radiology as a source for Medicare savings. Imaging programs should continue to focus on controlling costs as further reductions could be seen in future years.

2. Site-neutral payment adjustments reduced to 40% of hospital outpatient rate in 2018

In 2017, CMS implemented a site-neutral payment provision to reduce payment discrepancies between services performed at hospital outpatient departments (HOPDs) and provider-based sites. The policy mandates that newer off-campus HOPDs—those opened or acquired after November 1, 2015—receive reimbursement at a site-specific Medicare Physician Fee Schedule (MPFS) rate, which in CY 2017 is equal to 50% of the hospital rate.

CMS believed they overestimated the 50% rate in 2017. This summer, the agency proposed to cut the rate to 25% for 2018, based on a different analysis methodology.

In response to stakeholder concern, CMS conducted a third analysis of payment discrepancies using the top 22 codes billed at off-campus sites, eight of which were imaging services. From this analysis, the agency found that on average, provider-based sites are reimbursed at about 35% of the hospital rate. To account for additional variables like packaging, the agency set the 2018 site-neutral payment rates to 40% of hospital payments.

Impact on radiology: Moving forward, imaging leaders should continue to take site-neutral payment adjustments into consideration when relocating or building a new facility. Leaders should also anticipate greater rate changes in upcoming rules. Next year, CMS plans to use CY 2017 claims data with the hopes of calculating an even more precise payment rate. Even more dramatically, the agency is exploring fully transitioning impacted HOPDs to a MPFS claim instead of reimbursing on a reduced hospital outpatient rate.

3. Imaging clinical decision support (CDS) deadline delayed to 2020, but voluntary reporting period begins in July 2018

After proposing a delay in the provider deadline for the Appropriate Use Criteria (AUC) Program—also known as CDS—until Jan. 1, 2019, CMS has finalized an additional delay of the deadline until Jan. 1, 2020. This Jan. 1, 2020 date now represents the start of an “educational and operations testing period,” which means that there will be no financial penalties in place during this first year. Providers will be required to consult CDS and document usage, but Medicare would reimburse claims regardless of proper documentation in 2020. Reimbursement penalties are now expected to begin Jan. 1, 2021.

While delaying the mandate, the agency finalized AUC consultation as an Improvement Activity in the CY 2018 update to the Quality Payment Program (QPP). That means that referring providers who move ahead with CDS implementation will be able to score additional performance points under the MIPS track of MACRA. Read more here.